

3-15-2005

Toward a Unified and Reciprocal Disability System

Paul Armstrong

Follow this and additional works at: <http://digitalcommons.pepperdine.edu/naalj>



Part of the [Administrative Law Commons](#), [Disability Law Commons](#), and the [Social Welfare Law Commons](#)

Recommended Citation

Paul Armstrong, *Toward a Unified and Reciprocal Disability System*, 25 J. Nat'l Ass'n Admin. L. Judges. (2005)
available at <http://digitalcommons.pepperdine.edu/naalj/vol25/iss1/4>

This Article is brought to you for free and open access by the School of Law at Pepperdine Digital Commons. It has been accepted for inclusion in Journal of the National Association of Administrative Law Judiciary by an authorized administrator of Pepperdine Digital Commons. For more information, please contact Kevin.Miller3@pepperdine.edu.

Toward a Unified and Reciprocal Disability System

By Paul Armstrong*

I. INTRODUCTION

One of the fastest-growing areas of entitlement in our current social benefit system is in the area of disability benefits.¹ From very modest beginnings in 1956, the Social Security Disability System (SSD) in 2002 paid out a total of \$68 billion² to over 7 million disabled workers and dependents.³ In addition, the federally administered Supplemental Security Income Program (SSI) paid benefits to another 6.8 million persons, totaling more than \$34 billion, including about \$4 billion in federally administered state supplementation payments.⁴ Administering these two programs through a myriad of regulations and successive administrative strata is the largest unified adjudicatory system in the world, a system costing approximately \$2.5 billion and taking at times years to adjudicate a claim.⁵ It is the purpose of this paper to examine: (1) the

* This article was written by Paul Armstrong in his private capacity. No official support or endorsement by the Social Security Administration or the United States is intended or should be inferred. See 70 FR 7192.

1. GAO Report 02-597: SSA and VA Disability Programs: Reexamination of Disability Criteria Needed to Help Assure Program Integrity, U.S. General Accounting Office, August 2002, Figure 1, at 5 *available at* <http://www.gao.gov/new.items/d02597.pdf> (last visited March 24, 2005).

2. Social Security Administration: Facts and Figures about Social Security: General Information, August, 2003, *available at* http://www.ssa.gov/policy/docs/chartbooks/fast_facts/2003.

3. *Id.* Beneficiaries in Current Payment Status, 2002.

4. Social Security Administration, SSI Annual Statistical Report, 2002 (August 2003) *available at* http://www.ssa.gov/policy/docs/statcomps/ssi_asr/2002/ssi_asr02.pdr [hereinafter SSI Report].

5. Matthew Diller, *Dissonant Disability Policies: The Tensions Between the Americans with Disabilities Act and Federal Disability Benefit Programs*, 76 TEX. L. REV. 1003, 1016 (1998) [hereinafter Dissonant].

current disability system and the its underlying principles, (2) the political, economic, and legal changes that have occurred since its inception, both inside and outside the system, and how those changes impact the goals of the disability system, and (3) some proposed changes in the goals and procedures of the disability benefit system so as to bring it into accord with the changes that have occurred over the years. Part I of this paper will give a brief overview of the Social Security and SSI systems and how entitlement to benefits is established. Part II will examine the societal, medical, economic, and legal changes that have occurred both inside and outside these systems which may necessitate changes in the disability benefit policies underlying the SSD and SSI benefits system. Part III will examine the current situation of disabled individuals in the U.S., the conflicting views of the roles of disabled persons in our society, and reform proposals for the system. Part IV suggests specific changes in the system which may better implement a unified disability policy in this country, with specific references to experience with disability programs in private industry and other countries.

II. DESCRIPTION OF THE CURRENT SYSTEM

As more fully discussed below, while the program has grown and the character of the beneficiaries has changed over the years, the basic principles and procedures underlying the administration of the program have largely remained the same. Essentially, to qualify for disability benefits, an individual must not be working, must establish either that he is suffering from a severe medically-determinable impairment that has lasted or is expected to last at least twelve months or end in death,⁶ and meet the criteria of certain conditions defined by the Social Security Regulations as presumptively disabling (the Listings)⁷ or that his impairments are so severe that he cannot be employed at any occupation existing in significant numbers in the regional or national economy.⁸ If the individual is a worker who has earned over a minimum amount in at least twenty of the last forty calendar quarters,⁹ then that individual is paid in

6. 42 U.S.C. § 423 (2005).

7. 20 C.F.R. § 404, Subpart P, App. A (2004).

8. 20 C.F.R. § 416.905 (2004).

9. Social Security Administration: Annual Statistical Report on the Social

generally the same manner as if he had retired at full retirement age on the date he became disabled, while if he does not meet this test for insurability, then he is paid under the SSI only if he is indigent and only at a minimal subsistence rate.¹⁰ Both individuals will qualify for government-paid medical care, the worker after a two-year waiting period through the Social Security based Medicare program¹¹ and the non-worker (usually) through needs-based federal-state Medicaid.¹² The determination of a person's "disability" is first made by a state Disability Determination Service which investigates the individual's medical condition after his initial application at a local Social Security Office and issues an initial (and sometimes second) decision, and in the event of an appeal by a federal Administrative Law Judge after a recorded hearing.¹³ After a final decision of an Administrative Law Judge, a person claiming disability benefits can appeal to the Social Security Appeals Council and then to federal court.¹⁴

III. CHANGES REQUIRING MODIFICATION OF ORIGINAL SYSTEM

There are a number of factors that have converged at the turn of this century to make our current disability system medically, politically, socially, and economically unwise. In the first place, changes in the definition of disabled individuals who qualify for benefits have been substantially relaxed over the years both by actions of Congress and court decisions. This has resulted in a change in both the type of disability and the nature of the disabled person, with younger beneficiaries and more transitory ailments

Security Disability Insurance Program, 2002 (August 2003), at 5, *available at* http://ssa.gov/policy/docs/statcomps/di_asr/2001/di_asro02.pfd [hereinafter SSD Report].

10. The average monthly benefit under SSI in December, 2002 was \$ 407. SSI Report, *supra* note 4, at 1.

11. SSD Report, *supra* note 9, at 4.

12. Medicaid is a federal-state program that provides medical benefits to people based on need. Title XIX establishes two groups of needy persons, one of which is the "categorically needy" which are families with dependent children, aged, blind or disabled people who receive financial aid from federal programs, such as SSI. *See* 42 U.S.C. §§ 1396a(a)(10)(C), 1396a(a)(13)(B), 1396d(a)(1)-(5)(1988). Some states do not make this automatic, however.

13. SSD Report, *supra* note 9, at 5.

14. *Id.*

being represented. Advances in medical knowledge have minimized the effects of many acute causes of disability, such as accidents and infectious disease, allowed return to greater functionality through use of prosthetics and rehabilitation programs, and have led to a greater understanding of both the causes and the treatment of many chronic causes of disability. Statutory action by Congress has resulted in both the recognition and the implementation of principles of self-reliance, independence, and integration in the field of disability and public welfare law. But these changes have as yet not significantly altered the basic principles underlying the SSD and SSI disability benefit programs.

A. Changes in the Disability System and Beneficiaries Served

In discussing the disability system, it must be understood that the actions of Congress and the courts over the years have created a program far different from the one envisioned by the original writers of the Social Security Disability legislation. The program as first written was conceived as kind of an “early retirement” for “permanently” disabled workers and thus was limited to workers over fifty years of age.¹⁵ Because of this age restriction, there was little need to create an obligation on the part of the disabled workers to participate in medical or vocational rehabilitation, an obligation that opponents of the disability system felt was essential to its integrity.¹⁶ However, Congress in 1960 removed the restriction on qualification for disability benefits to those under 50 years old¹⁷ and in 1965 replaced the requirement of permanent disability with a rule that the disabling medical condition was expected to last at least a year.¹⁸ Equally significant was the judicial activism of the courts in expanding the definition of disability in mental illness cases, a trend most evident in the area of drug and alcohol addiction but common to the entire gamut of mental disabilities, from mental retardation to

15. 42 U.S.C. § 423 (2004).

16. Matthew Diller, *Entitlement and Exclusion: the Role of Disability in the Social Welfare System*, 44 UCLA L. REV. 361, 406 (1996) [hereinafter *Entitlement*].

17. Social Security Act Amendments of 1960, Pub. L. No. 86-778, 401 (codified in scattered sections of 42 U.S.C.).

18. 42 U.S.C. § 423 (2005).

depression. Because federal courts began requiring a more subjective and individualized examination of the capacity of a person alleging mental disability to work,¹⁹ awards for mental disabilities rose from 11% of SSD and 18% of SSI beneficiaries in 1981²⁰ to where today they comprise almost a third of the SSD beneficiaries²¹ and comprise by far the largest (almost 6 in 10) category of SSI disability recipients.²² Because the Medical-Vocational Guidelines (Grids),²³ which now codified the more favorable treatment given to those over fifty, could not arguably be applied in mental illness cases, by 2002 individuals with mental disabilities other than retardation comprised by far the largest category of SSD beneficiaries under the age of fifty.²⁴ Significantly, a 2002 GAO Report noted that in 1999 one in nine SSD beneficiaries suffered from an "affective disorder" (depression, bi-polar, or other mood disorder) which SSA research indicated could be controlled with appropriate treatment in as many as 60% of the cases.²⁵

In 1972, Congress merged the means-based state welfare programs that formerly existed as the Aid to Totally and Permanently Disabled (APTD) Program into a new SSI program that adopted the same definition of disability as the SSD program.²⁶ While this program had formerly been administered by the states under broad interpretations set out by the federal government, many states had interpreted the eligibility criteria in a liberal manner.²⁷ The establishment of SSI gave a uniform national eligibility criterion, inflation-indexed benefits, and some perceived favored status to the disabled GA beneficiaries as compared with other welfare

19. Jennifer Erkulwater, *The Judicial Transformation of Social Security Disability: The Case of Mental Disorders and Childhood Disability*, 8 CONN. INS. L.J. 401, 415 (2001).

20. Social Security Reviews of the Mentally Disabled: Hearing before the Special Committee on Aging, 98th Cong. 164-65 (1983).

21. SSD Report, *supra* note 9, at 2.

22. SSI Report, *supra* at note 4, at Table 25.

23. 20 C.F.R. § 404 Subpt. P App. 2.

24. SSD Report, *supra* note 9, at 98-101.

25. GAO Report 01-153: SSA Disability: Other Programs May Provide Lessons For Improving Return-to-Work Efforts, U.S. General Accounting Office: January, 2001, 29-30.

26. 42 U.S.C. §§ 1381-1383d (2005).

27. Entitlement, *supra* note 16, at 429-31.

beneficiaries.²⁸ However, the merging of the two disability benefit programs under a definition of disability created under an "early retirement" paradigm brought into play the very factors that opponents of the program had feared would overcome it. As Diller points out in his examination of the differing origins of the SSD and APTD systems, opponents of the SSD system feared that it would attract poor workers looking for an excuse to leave the workforce²⁹ and would create a significant disincentive on the part of those that could work.³⁰ The proponents of SSD countered that the requirement of recent and sustained work activity, together with the minimum age limitation of 50 set out above, effectively ensured the program against these dangers.³¹ The problem is that when the disability programs expanded (through broadening of the statutory definition of disability and incorporating SSI with no prior earnings requirement) to cover younger individuals with more transitory (as opposed to permanent) impairments and less connection to the workforce, they had little or no mechanism for policing against the larger numbers of younger individuals inevitably attracted by the benefits provided in these programs. The Carter Administration addressed this issue through disability act amendments in 1980 which mandated a periodic review of the disability rolls to weed out such individuals, a process that was pounced upon by the Reagan Administration in its controversial and ultimately unsuccessful attempt to accelerate the review process.³² This same problem has been recognized and addressed more recently in The Ticket to Work and Financial

28. Entitlement, *supra* note 16, at 445-46.

29. *Id.* at 405 n.138.

30. *Id.* at 406 n.141 (citing testimony in Hearings before The Senate Committee on Finance on H.R. 7225, 84th Congress. 406 (1956) at 547, where Dr. Edward Stieglitz testified: "Apparently there has been great difficulty in attempting to define disability...The question is: When [is] a man disabled or when is a woman disabled? Fundamentally, it is when the individual quits trying").

31. *Id.* at n.141, 145-47. As noted by the Social Security Advisory Council in 1948, "the 'strict test of long-term attachment to the labor force' would provide convincing proof of both the ability to work and the ability to earn income over a substantial period of time," S. Doc. No. 80-162, at 1 (1948).

32. Erkulwater, *supra* note 19, at 411-12. As more fully set out in the Erkulwater article, this accelerated review process not only resulted in the suspension of the review process but the significant reduction in the capacity of the Social Security Administration to conduct further reviews.

Incentives Act of 1999,³³ a program that has been equally dismal in its results.³⁴ When looked at in the context of the origins of the SSD program from which the definition of "disability" and the process used to determine its existence in both programs is drawn, the problem created by the definition and determination process is not hard to recognize. Younger individuals with more transitory medical or psychological impairments are necessarily more likely to recover some form of functionality, either through treatment, training, or changes in habit that may enable them to return to some form of gainful employment. The "early retirement" disability program created in 1956 contained no provision for assessing return to work capabilities and thus ignored that potential. As the GAO reported in 2001, private insurers and European countries routinely assess and provide vocational rehabilitation services to individuals in their disability programs at an early stage in the process,³⁵ but the SSA has no provision for assessment, medical, or vocational rehabilitation services until after a claimant has already proved his disability.³⁶ Once beneficiaries are already on long-term disability rolls, even private insurers report that only 2-3% either returned to work or were removed from their rolls due to a determination that they had the capacity to work.³⁷ The procedure adopted by the creators of the SSD program, because it was based on the "early retirement" paradigm, made no provision for reviews. The SSA procedure for conducting continuing disability reviews finally adopted was generally limited to actual medical improvement, provided no mandatory rehabilitation requirement, and was subject to numerous technical hurdles.³⁸

33. 42 U.S.C. §§ 13206-13219 (2004).

34. See Bruce S. Growick & Judith L. Drew, *The Ticket to Work: The Unintended Consequences of an Imperfect Law*, 6 J. OF FORENSIC VOCATIONAL ANALYSIS 49 (2003). As of March 2003, 2.3 million "Tickets" had been issued and only 13,511 had been assigned, less than 3/4 of 1%. This is similar to the 1/2 of 1% of workers whose benefits were terminated based upon a successful return to work. Annual Statistical Report on the Social Security Disability Insurance Program, 2002, August, 2003: Social Security Administration, Table 49.

35. GAO Report 01-153, *supra* note 25, at 14-24.

36. *Id.* at 23.

37. *Id.* at 13.

38. See 20 CFR § 404.1530(a) (2004); see also *Shramak v. Apfel*, 226 F.3d 809 (7th Cir. 2000) (where an ALJ was reversed when she terminated benefits due to the failure of the claimant to quit smoking).

B. Scientific Advances Confirm Connection Between Disability and Voluntary Lifestyle Choices

As our country has advanced in fighting infectious diseases and other acute threats to health, research has turned to the causes of more chronic illnesses plaguing modern society and upon which a finding of disability may be based. A publication issued by the World Health Organization in 2002 noted that at least one-third of the entire disease burden in the industrialized societies of North America, Europe, and Asia is caused by tobacco, alcohol, blood pressure, cholesterol, and obesity.³⁹ A recent study of more than 900,000 women and men concluded that obesity is a significant risk factor for, in addition to heart disease, cancer generally and for cancer in several specific body sites.⁴⁰ Numerous studies confirm a correlation between obesity and disability.⁴¹ The medical literature is replete with studies confirming the adverse health effects and resulting disability caused by smoking.⁴² Diabetes has been positively linked with obesity and a sedentary lifestyle.⁴³

Equally compelling have been the studies that confirm the beneficial effect on health outcome from relatively straightforward lifestyle changes, such as smoking cessation, exercise, and weight loss. Exercise programs have been effective in dealing with common disabilities such as low back pain,⁴⁴ chronic neck pain,⁴⁵

39. World Health Report 2002, World Health Organization: Geneva, Switzerland, 2003, 8 *available at* <http://www.who.int/whr/2002/en/whroz.en.pdf> (last visited March 12, 2005).

40. Eugenia E. Calle, et al., *Overweight, Obesity and Mortality from Cancer in a Prospectively Studied Cohort of U.S. Adults*, 348 NEW ENG. J. MED., 1625-28 (2003).

41. Evette Weil, et al., *Obesity Among Adults with Disabling Conditions*, 288 JAMA 1265-68 (2002).

42. Centers for Disease Control, *Annual Smoking-Attributable Mortality, Years of Potential Life Lost and Economic Costs, 1995-99*, 51 MORBIDITY AND MORTALITY WEEKLY REPORT, 300-04 (April 12, 2002).

43. Claire M. Steppan, et al., *The Hormone Resistin Links Obesity to Diabetes*, 409 NATURE, 307-12 (2001).

44. Matthew W. Lively, *A Sports Medicine Approach to Low Back Pain*, 95 SOUTHERN MED. J., 642-45 (2002). At the time that this paper was written, a local television station was running a story on a health care practitioner who claimed to have a ninety percent success rate in the reduction of elimination of often crippling back pain through use of exercise based on martial arts principles. See

fibromyalgia,⁴⁶ and other ailments. Regular physical exercise has been shown to be one of the most effective treatments for many forms of mental illness⁴⁷ and may even increase mental alertness and engagement.⁴⁸ Smoking cessation is cited by the Surgeon General as a major factor in reducing disability.⁴⁹

These advances in scientific knowledge of the causes of common disabilities and the nature of the treatment which serves to improve health outcomes has a profound impact on the basis of our current disability programs. The foundation of our disability benefit system is the principle that there are some people who, despite their own best efforts, are physically unable to hold a job. But the foregoing literature casts considerable doubt on this underlying assumption. Based upon emerging scientific knowledge as to the causes and treatment of many common disabling conditions, the disabled individuals in many cases have much more control over the progress of their conditions through the adoption of many simple (I did not say easy) healthy lifestyle choices, such as smoking cessation, weight loss, and exercise.

Let me clarify a point here. There are many conditions of genetic origin; others caused by accidents or environmental conditions which are considered "out of the control" of the individual; still others of unknown etiology and some which are clearly the result of adverse "lifestyle" choices such as smoking, drug and alcohol use, a

Sylvia Perez, Kicking Back Pain, ABC7, at <http://abclocal.go.com/wls/news/specialsegments/112603.ss.backpain.html> (last viewed Nov. 29, 2003).

45. Roni Evans, et al., *Two Year Follow-up of a Randomized Clinical Trial of Spinal Manipulation and Two Types of Exercise for Patients with Chronic Neck Pain*, 27 SPINE 2383-89 (2002).

46. Wingers, et al, *Effects of Aerobic Exercise Versus Stress Management Treatment in Fibromyalgia A 4.5 year Prospective Study*, 25 SCAND. J. OF RHEUMATOLOGY, 77-86 (1996); see also Nutting, et al, *An Exercise Program in the Treatment of Fibromyalgia*, 23 J. OF RHEUMATOLOGY, 1050-53 (1996).

47. Daniel M. Landers, *The Influence of Exercise on Mental Health*, PCPFS RESEACH DIGEST, Vol. 2, No. 12 (1998); see also D.A. Lawler & S.W. Hopkner, *The Effectiveness of Exercise as an Intervention in the Management of Depression*, 322 BMJ 1, 1-8 (2001).

48. Exercise Gets Blood to Your Brain, REUTERS (Nov. 8, 2003).

49. Report of the Surgeon General, Reducing Tobacco Use, U.S. Department of Health and Human Services (2000), available at http://www.cdc.gov/tobacco/sgr/sgr_2000/fullreport.pdf.

sedentary lifestyle, and poor diet. The scientific knowledge confirming links between many disabling conditions and voluntary "lifestyle" choices affects SSD and SSI disability benefit programs in two distinct ways. First, it tends to erode support for benefits that are not time-limited or otherwise qualified so as to discourage "voluntary" behavior that might qualify for benefits (in the same way that support for the ADC program was eroded due to the perception that unsupported pregnancies and children were "voluntary" choices of the individuals involved).⁵⁰ This is not to say that the disability benefit program did not in the past award disability benefits to many persons who, like the motorcycle driver who suffered a traumatic brain injury because he was not wearing a helmet, were certainly responsible for their own disabling condition. But as the attitudes about common "disabilities" such as diabetes, respiratory impairments, and obesity change, support for unqualified assistance through a guaranteed benefit program of cash and other benefits may tend to erode. Second, the scientific knowledge as to effective treatment of such conditions, and the control the "disabled" person has over the progress of his or her condition, tends to encourage the principle of "mitigation" of the disabling condition to the extent "reasonable"⁵¹ under the circumstances. I will discuss in more detail in Section III the theoretical implications of advances in scientific knowledge on disability benefit programs and in Section IV try to integrate these advances into suggested modifications in the disability benefit programs.

C. Political and Legal Changes

The most significant piece of legislation with respect to persons with real or perceived disabilities was the Americans with Disabilities Act of 1990.⁵² Hailed by supporters as "the 20th Century

50. See Amy Wax, *A Reciprocal Welfare Program*, 8 VA. J. OF SOC. POL'Y & L. 477, 496 ("The long turning of the tide away from willingness to support single parents goes hand-in-hand with a growing consensus that the decision whether or not to become a mother is increasingly under the individual's control. Birth control and abortion have become safer, increasingly available, and more reliable.").

51. *Id.* at 493.

52. 42 U.S.C. §§ 12101-12213 (2005).

Emancipation Proclamation for all persons with disabilities,”⁵³ the law prohibited discrimination against persons with disabilities and provided access to those persons in a wide range of public activities, including employment. One of the most litigated of the employment provisions required employers to provide “reasonable accommodations” in order to employ persons with disabilities.”⁵⁴ While there has been a great deal of litigation and resultant commentary on the rather restrictive view of the U.S. Supreme Court and lower courts in interpreting the scope of the employment provisions of the Americans with Disabilities Act, Bagenstos makes a persuasive argument that these restrictive interpretations are largely supported by the arguments made by proponents of the Act as a welfare reform statute for the disabled.⁵⁵ Bagenstos traces the origins of the disability rights movement which culminated in the passage of the Americans with Disabilities Act to the Independent Living Movement of the early 1970s, a movement which specifically eschewed dependence on charity or disability benefits in favor of personal responsibility, independence, and the “dignity of risk.”⁵⁶ To the intellectuals involved in this movement, it was important for the individual with a disability to depend on his or her own industry rather than on the welfare state.⁵⁷ These arguments dovetailed neatly with the conservative bent of the 1980s and early 1990s. The National Council on the Handicapped in its 1986 report, *Toward Independence*,⁵⁸ advocated a new federal law, perhaps titled “The Americans with Disabilities Act of 1986,” which would prohibit discrimination against the handicapped in a “clear, consistent and enforceable”⁵⁹ manner and argued that the \$60 billion annual federal spending on disability benefits and programs could be spent “more prudently and productively.”⁶⁰ In a hearing before a Senate Subcommittee considering the ADA, disability analyst Edward

53. Dissonant, *supra* note 5, at n.5 (citing Statement of Senator Harkin, chief sponsor of the bill, 136 Congressional Record S9689 (daily ed. July 13, 1990)).

54. 42 U.S.C. §12111(9) (2000).

55. Samuel R. Bagenstos, *The Americans with Disabilities Act as Welfare Reform*, 44 WM. & MARY L. REV. 921 (2003).

56. *Id.* at n.327, 329.

57. *Id.* (referring to quotations from Nosek Tarita, the Darts and DeJong).

58. National Council on Disability, *Toward Independence* (1996).

59. *Id.* at 18.

60. *Id.* at vi.

Berkowitz estimated the cost of U.S. public and private disability programs at \$170 billion per year.⁶¹ As most succinctly stated in a published letter to the editor of the Wall Street Journal by then Attorney General Dick Thornburgh in 1989:

For too long federal policy has provided massive financial resources for income support programs to maintain individuals with disabilities in a state of dependency. The new legislation, on the other hand, will promote the independence of people with disabilities to enable them to enter into the mainstream of American Life. By removing barriers to full participation by disabled individuals, the bill will have direct and tangible benefits to the economy. The result will be more disabled people working, increased earnings, less dependence on the Social Security system, increased spending on consumer goods and increased tax revenue.⁶²

Indeed, Berkowitz argued persuasively that SSD and SSIs should be reformed to incorporate the work inducements of the ADA.⁶³ The subsequent restrictive interpretations in the courts' decisions defining a "qualified" person with a disability, especially the requirement that mitigating measures be used in considering whether there is a disability,⁶⁴ and use of judicial estoppel to prohibit a person from both seeking accommodation as a person capable of performing the "essential functions" of a job⁶⁵ and seeking disability benefits based upon the contention that "he is...unable...to engage in any...kind of

61. Americans with Disabilities Act of 1989: Hearing on S. 933 before the Subcommittee on the Handicapped of the Senate Committee of Labor and Human Resources, 101st Cong. 370-74 (1989).

62. Bagenstos, *supra* note 55, at 972-73 (quoting Dick Thornburgh, *Toward Independence for the Disabled*, WALL STREET JOURNAL, Oct. 6, 1989, at A 13).

63. Entitlement, *supra* note 16.

64. See *Sutton v. United Airlines*, 527 U.S. 471 (1999) (holding that a pilot whose eyeglasses corrected her vision to 20/20 from 20/200 and 20/400 was not "a person with a disability" as defined by the ADA); see also *Murphy v. United Parcel Service*, 527 U.S. 516 (1999) (holding that hypertension that was controlled with medication was likewise not a "disability" under the ADA).

65. 42 U.S.C. § 12112(a).

substantial gainful work,”⁶⁶ seem consistent with a policy that ADA protections should be accorded only those actively seeking work who might not otherwise be employable without accommodation. In other words, the linkage between the ADA and reduction in disability benefit program rolls is apparent in the arguments made for the passage of the ADA and implicit in the court interpretations of that Act subsequent to its passage. Since the ADA plaintiffs in *Sutton* and related cases were qualified for many *other* jobs in the national economy, they would not be “disabled” under the definition of the SSD and SSI disability benefit criteria. Similarly, although in *Cleveland* the court distinguished between the conflicting definitions of “disability” contained in the ADA and the SSD and SSI disability benefit programs, it is clear that courts may consider a claimant’s contentions in a filing for disability benefits and his or her contentions in an ADA claim as, in some cases, mutually inconsistent.

A second legal development that has eroded the underpinnings of the current disability income program was the Personal Responsibility and Work Opportunity Act of 1996,⁶⁷ which eliminated the Aid to Families with Dependent Children (AFDC) program in favor of a more limited program (Temporary Assistance to Needy Families-TANF) which required self-sufficiency attempts and limited lifetime benefits to at most five years. An important part of this program was a mandatory work requirement that the individual States would have to implement through vocational or other work programs.⁶⁸ While it is probably too early to judge the total impact of the program on poverty among single parents, the law has reduced caseloads markedly.⁶⁹ In her article, *A Reciprocal*

66. 42 U.S.C. § 423(d)(2)(a) (2004). Bagenstos argues that despite the U.S. Supreme Court decision in *Cleveland v. Policy Mgmt Sys.*, 526 U.S. 795 (1999), courts routinely grant summary judgment to defendants in ADA cases where any statement of the ADA plaintiff in an SSD claim is incompatible with the contention that the individual is “qualified” to do the job for which accommodation was requested.

67. Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, 110 Stat. 2105 (1996).

68. See Dan Bloom, *After AFDC: Welfare to Work Choices and Challenges for States* (1997).

69. Tim Jones, *Welfare Reform Fails to End Poverty*, CHICAGO TRIBUNE, Sept. 30, 2003 at 9 (discussing the experience of Wisconsin, which saw a decline of

Welfare Program,⁷⁰ Amy Wax examines the changing social attitudes regarding women and particularly single mothers in the workplace and concludes that these changes inevitably resulted in uneasiness with “allowing some mothers to depend almost entirely on public support while others with similar attributes succeed in maintaining greater independence.”⁷¹ Another factor in the erosion of public support for the AFDC program was the increasing consensus that reproductive decisions ultimately represented the conscious choice of the prospective mother. These factors undermined the idea of continued public support for mothers with dependent children based upon the doctrine of reciprocity. Wax asserts that all social arrangements are ultimately based on reciprocity, which leads to the imposition of a doctrine that “persons should strive for self-sufficiency if the effort required is within the realm of reason, with the standard of reasonable exertion informed by the conventional expectations and by what most people do.”⁷² While the initial disability program incorporated the concept of “reciprocity” in its disability “insurance” program by means of mandatory deductions from a worker’s paycheck to cover the eventuality of an unforeseen “disability” before retirement, as discussed above, the expansion of the national disability programs to include non-workers under SSI and younger individuals with disabilities that might be amenable to rehabilitation has changed the system in a way that perhaps requires a revision in the “reciprocity” paradigm. As Wax points out in her subsequent article *Disability, Reciprocity and “Real Efficiency”: A Unified Approach*:

It is hard to see why persons with conventional disabilities should ever be categorically excused from expending the reasonable work effort that we routinely expect from persons who have difficulties on the job market for other reasons. Persons whose paucity of marketable skills prevent them from obtaining jobs that pay enough to support themselves

80% in its caseload over the last decade under the aggressive Wisconsin Works (W-2) program but still noted considerable poverty in a core of poor people).

70. Wax, *supra* note 50, at 477.

71. *Id.* at 495.

72. *Id.* at 493.

or their families, regardless of the cause of the deficit, are nonetheless expected to work. This expectation suggests that we should jettison the notion that having a medical disability excuses nonwork altogether.⁷³

It is certainly possible that changing attitudes about the possible productivity of disabled individuals, induced in part by the rhetoric of the ADA supporters and their repeated use of successfully productive examples of disabled individuals, together with the experience of declining caseloads of former AFDC recipients under the mandatory work requirements of TANF, may lead to public support for mandatory vocational evaluations and work referrals for disability applicants and recipients.

At about the same time as it was restructuring the AFDC welfare program, Congress was acting to restrict government benefits to disabled SSD or SSI recipients in another area of individual "choice": alcohol and drug addiction. Due to judicial decisions and the general medical consensus that drug addiction and alcoholism (DA&A) were "diseases" in their own right, the Social Security Administration had recognized these as medically determinable impairments which could warrant a finding of disability benefits independently of any mental or physical impairments (such as liver damage or dementia) that might result from the chronic use of such intoxicants.⁷⁴ Recovery for this disability was severely restricted in 1994,⁷⁵ limiting benefits to three years and requiring that disabled addicts seek treatment for their addictions. In 1996, payments to SSD and SSI beneficiaries due to DA&A were cut off completely.⁷⁶ Thus, for a two-year period between 1994-1996, these programs required addicts and alcoholics to actively seek treatment for their "disabilities" and granted time-limited benefits and targeted medical treatment to these individuals in order to foster their rehabilitation. The sudden cutoff of these benefits was unfortunate in that it did not allow for the complete implementation of the program and evaluation of the efficacy of the imposition of positive health choices on the part of disability

73. Amy L. Wax, *Disability, Reciprocity and "Real Efficiency": A Unified Approach*, 44 WM. & MARY L. REV. 1421, 1446-47 (2003).

74. 20 C.F.R. Part 404, Subpt P, App. A (1985).

75. Pub. L. No. 103-296 (1994).

76. Pub. L. 104-121 (1996).

beneficiaries. In fact, studies confirmed that the cutoff resulted in many addicts “dropping out” of treatment, losing their housing, committing suicide or turning to crime, and very few returned to gainful employment.⁷⁷ The negative results from this cutoff suggest that a punitive approach based upon restricting social disability benefits under SSI and SSD based upon the unhealthy or unwise past “lifestyle” choices of the applicant/recipient may not be effective. A non-punitive approach would seem to be the politically-accepted goal incorporated in the TANF program, where mothers with dependent children are not penalized for their (perhaps) unwise past choices but are instead given support conditioned on reasonably-required work effort.⁷⁸

Another statutory development that reflects on the goals of our current disability income programs is the Ticket to Work and Work Incentives Improvement Act of 1999.⁷⁹ This law addressed concerns regarding loss of medical coverage by those coming off disability rolls, and allowed for the purchase of Medicaid coverage by certain low-income disabled workers and the extension of Medicare benefits for up to five years after a disabled individual comes off of SSD benefits due to employment. The cornerstone of the program was the provision of “tickets” to disabled beneficiaries which allowed them, at their option, to obtain free vocational rehabilitation and assistance services to be paid for by the federal government based upon the savings to the disability system accruing from the now-employed beneficiary. The program was developed in response to continued prodding of the SSA by the GAO to implement a comprehensive vocational rehabilitation policy in its disability programs.⁸⁰ While it is again very early in the program implementation period, initial results of the program are not encouraging,⁸¹ and a recent GAO report urged more fundamental policy changes in the system to address return-to-work goals.⁸²

77. Dru Stevenson, *Should Addicts Get Welfare? Addiction & SSI/SSD*, 68 BROOKLYN L. REV. 185, 196-202 (2000).

78. Wax, *supra* note 50, at 497.

79. 42 U.S.C. §§ 13206-13219 (2005).

80. See GAO/HEHS 96-133, July 11, 1996; see also SSA Disability Program Redesign Necessary to Encourage Return to Work (GAO/HEHS 96-62, April 24, 1996).

81. Growick & Drew, *supra* note 34, at 53.

82. GAO Report 01-153, *supra* note 25, at 39.

IV. CURRENT SITUATION OF THE DISABLED AND EMERGING VIEWS OF THE DISABLED IN SOCIETY

Estimates from the United States Census indicate that in 1990, 48.9 million Americans aged 21 to 64 (19.4%) had a disability and that number had increased to 53 million in 1997.⁸³ About one-half of those individuals had “severe” disabilities, or those generally requiring assistance with daily activities, using an assistive walking device or qualifying for federal disability programs based upon inability to work.⁸⁴ The unemployment rate for those with severe disabilities is about 70%, with the unemployment rate for non-severely disabled at 18%.⁸⁵ The poverty level for people with disabilities is high (27.9%) and their level of home ownership is extremely low (less than 10%).⁸⁶ Of the people with disabilities who are not working, 72% said in a widely reported 1998 Louis Harris poll, that they would like to work.⁸⁷ There have been a number of statutory attempts to spur employment among the disabled, including the ADA, the Ticket to Work program and the various work incentive programs in SSD and SSI systems, such as the trial work period,⁸⁸ the extended eligibility period⁸⁹ and certain earned income retention benefits under SSI.⁹⁰ But studies assessing the impact of the ADA have been equivocal at best, and any exodus from the disability rolls envisioned by the above reforms has certainly not materialized. For example, only 0.5% of all social security disability beneficiaries leave the disability rolls because of a successful return to work⁹¹ and less than 0.75% of the “tickets” under the federal Ticket to Work program have been assigned as of March 2003.⁹²

83. Rich, et al, *Critical Legal and Policy Issues for People with Disabilities*, 6 DEPAUL J. OF HEALTH CARE LAW 1, 6 (2002).

84. *Id.* at 4 (referring to definition of disability items in Census, 2000).

85. *Id.* at 7-8 (citing census statistics from 1997).

86. *Id.*

87. See Great Lakes Disability & Business Assistance Center, Harris Poll Results, Region V News, Spring/Summer, 1998, at 1.

88. 42 U.S.C. § 422(c)(4)(A) (West 2005).

89. 42 U.S.C. § 423(e)(1) (West 2005).

90. 42 U.S.C. § 1382a(3)(A).

91. ANNUAL STATISTICAL REPORT ON THE SOCIAL SECURITY DISABILITY INSURANCE PROGRAM, 2002, Table 49 (released August 2003), available at http://www.ssa.gov/policy/docs/statcomps/di_asr/2002/exp_toc.html.

92. Growick & Drew, *supra* note 34, at 53.

In his historical survey of the relationship of the disabled to our society as a whole, Weber points out that early policy was based upon the concept of custodialism.⁹³

“Custodialism is the idea that persons with disabilities are to be sheltered – that they should be kept separate from the population at large and given charity to compensate for their inability to survive on their own.”⁹⁴ Weber points to laws such as the Chicago ordinance prohibiting persons who were “deformed” or “unsightly” from exposing themselves in public or forced sterilizations of feeble-minded women based upon the pseudo-science of Eugenics as examples of policies of custodialism.⁹⁵ The emphasis of custodialism was on the fundamental differences existing between the disabled and nondisabled person and not on their fundamental equality.⁹⁶ The principles underlying our current disability benefits systems, such as the division of applicants into “disabled” and “nondisabled” persons, the segregation of “disabled” persons from the work force and provision of generally unconditional income support payments to those found to be “disabled” seem to draw on the ideas underlying custodialism.

As noted in the previous discussion on the ADA, this act was formulated and passed, in part, by the very aggressive reaction of many disabled people to the paternalistic attitude embodied by custodialism. This new policy was termed integrationism, and emphasized the voluntary and compulsory application of technology, along with attitudinal and environmental changes compelled by antidiscrimination laws, in fully integrating the disabled as equals into our society. As noted by Weber, the ADA is a classic integrationist statute, prohibiting discrimination in employment (including “reasonable” accommodations for qualified disabled workers) and mandating alteration of public buildings, transportation, telecommunication and other services to promote accessibility by persons with disabilities.⁹⁷ Weber points out, however, there are inherent limitations in the integrationist perspective. Because the

93. Mark Weber, *Disability and the Law of Welfare: A Post-Integrationist Examination*, 2000 U. ILL. L. REV. 889 (2000).

94. *Id.* at 889.

95. *Id.* at 900-01.

96. *Id.* 899-900, n.69.

97. *Id.* at 903-04.

rights embodied in the ADA are subject to interpretation by courts and agencies, they may be significantly limited or withdrawn at the will of the majority (nondisabled). Unconscious discrimination and stereotypes might cloud an employer's decision. Many disabled persons may be hesitant to seek enforcement of rights through legal remedies. Limits of "reasonableness" in accommodation could be applied restrictively so as to discourage employment or major construction alterations. More fundamentally, the person with a disability is generally not as productive as a non-disabled worker, all other things being equal, and thus there is a disincentive on the part of any employer to hire such a worker, whether or not an accommodation is required.⁹⁸ To make up for the fundamental differences in productivity between disabled and nondisabled persons, Weber argues that affirmative actions must be taken by society through mandatory income redistribution and/or job set-asides to "equalize" the condition of the disabled.⁹⁹ He termed this doctrine "post-integrationism."¹⁰⁰

The post-integrationist approach was most recently discussed in the context of reciprocity in Wax's article on disability.¹⁰¹ According to Wax, a just society is based upon what John Rawls terms the reciprocal cooperation among equals.¹⁰² In practical application, this would involve in Wax's view reciprocal obligations on the part of the individual to exercise reasonable efforts at self-sufficiency¹⁰³ in return for a government guarantee of a basic standard of living.¹⁰⁴ With respect to the disabled, this would involve the reinterpretation of social benefit programs so as to incorporate the obligation to exercise good-faith "reasonable" efforts at self-supporting work in return for a public subsidy to "make up the difference."¹⁰⁵ Wax suggests that this duty to work might necessitate more aggressive

98. *Id.* at 905-06.

99. Weber, *supra* note 93, at 917. See also Mark Weber, *Beyond the Americans with Disabilities Act: A National Employment Policy for People with Disabilities*, 46 BUFF. L. REV. 123 (1998).

100. Weber, *supra* note 93, at 913-14.

101. Wax, *supra* note 73, at 1446-48.

102. Wax, *supra* note 50 (referencing Rex Martin, *Rawls's New Theory of Justice*, 69 CHI-KENT L. REV. 737, 750-51 (1994)).

103. Wax, *supra* note 50, at 493.

104. *Id.* at 496.

105. Wax, *supra* note 73, at 1446-48.

efforts on the part of society to accommodate the disabled worker in many cases, even if the burden on the employer is economically unreasonable, as in most cases the economic burden placed on the employer through accommodation and/or productivity differential will be more than offset by the savings to society in general in the form of unpaid disability benefits. Among her recommendations for disability benefit programs is that they move away from the bright line “all or nothing” disability approach and that there be a renewed emphasis on rehabilitation, vocational counseling, and job placement for the disabled.¹⁰⁶

The GAO Report discussed earlier examined aspects of various private insurance disability programs and public programs in three European countries,¹⁰⁷ and noted significant changes between their systems and that in the SSD/SSI system. Most significantly, all of the disability systems used by private insurers and in the European countries incorporated return-to-work evaluation and enhancement in their initial disability determination process.¹⁰⁸ For example, each of the private insurers made an initial determination as to whether the disability applicant was able to return to his prior work and, if not, a determination of the applicant’s remaining work potential.¹⁰⁹ If the insurer determined that the applicant had work potential, the insurer then developed and implemented an individualized return to work strategy.¹¹⁰ With the applicants that were deemed without rehabilitation, potential a much less aggressive and costly monitoring procedure was set up to handle the claim.¹¹¹ All three private insurers incorporated varying definitions for “disability” during the different stages of the evaluation process: more liberal at the beginning and becoming progressively more restrictive for a period of usually two years.¹¹² The private insurers involved required the disabled person’s participation in vocational rehabilitation at the cost

106. *Id.* at 1450.

107. The insurers involved were UNUMProvident, Hartford Life and CIGNA, and the European Countries were Germany, Sweden and the Netherlands. GAO Report 01-153, *supra* note 25, at 5.

108. *Id.* at 14.

109. *Id.* at 18.

110. *Id.* at 16, Figure 1.

111. *Id.* at 35-36.

112. *Id.* at 15, 18.

of the loss of benefits¹¹³ and offered monetary incentives, including the ability to earn substantial sums and retain disability benefits¹¹⁴ to their beneficiaries. All of the insurers involved both required and assisted in providing appropriate medical treatment to mitigate the claimant's disability.¹¹⁵ Similarly, the European governments involved emphasized an early return to work evaluation, provision of medical and vocational assistance, and the denial of benefits to claimants who refuse to engage in vocational rehabilitation,¹¹⁶ although the availability of universal health benefits and the imposition of significant duties on private employers make exact comparison with the SSD/SSI program impossible.

While the history of past SSA disability return to work initiatives is not encouraging, the current Commissioner has embarked on a far-reaching overhaul of the disability determination process.¹¹⁷ A number of new demonstration projects are planned, all of which tend to address shortcomings of the current work incentives program in the disability benefit programs.¹¹⁸ The first project is a type of "temporary allowance" which may be made in serious cases where an individual's condition is expected to improve if support and rehabilitation are given sooner in the process rather than later.¹¹⁹ Expert reviewers would screen the cases and individuals would be allowed cash benefits and medical coverage for twelve, eighteen, or twenty-four months. It is hoped that during this time they will

113. *Id.* at 25-26.

114. *Id.* at 26.

115. *Id.* at 27.

116. *Id.* at 28.

117. Hearing on the Social Security Administration's Management of the Office of Hearings and Appeals Before the House Comm. on Ways and Means, 108th Cong. (2003) (testimony of Jo Ann B. Barnhart, Commissioner, Social Security Administration). The "record" of an SSD/SSI claims file is the total paper record of the disability application, work history and other documents filled out by the claimant together with all of the medical records obtained by the state DDS in investigating and evaluating the claim. It should be noted that the timing of the electronic file implementation coincides with the implementing of the requirement for conversion to electronic medical records in the private sector.

118. Robert Isbell, Summary of Comments Made by Commissioner Barnhart and Deputy Commissioner Gerry to Advocacy and Professional Groups, Sept. 26, 2003 in Washington, D.C.. See also GAO Report 01-153, *supra* note 25, at 30-31.

119. Commissioner Barnhart, *Testimony Before the House Comm. on Ways and Means*, *supra* note 117.

improve and return to work. After this time the individuals will be reviewed and, if they have not returned to work, they will go through the regular disability procedure.

The second pilot project is an early intervention project designed by Monroe Berkowitz from Rutgers University.¹²⁰ This program targets beneficiaries who have not yet had any determination as to their entitlement to benefits made by the Social Security Administration. Under this program, the Social Security Administration would screen initial applicants for both their likelihood of receiving benefits and their reasonable expectation for success in a return to work program.¹²¹ If the applicant passes both these screens, he or she is given a choice as to whether to proceed with the disability application in the normal manner or volunteer to participate in a return to work program. If they choose the return to work option, the program is designed to offer various incentives based upon various models. Certain of the early intervention initiatives contemplate that temporary benefits would be paid, medical services provided, or vocational services would be offered by private or public vocational agencies.¹²² Providers (who may be vocational experts or even attorneys) could be compensated on a contingent basis by as much as 50% of the money saved by the trust fund on a successful return to work.¹²³ A third pilot program would involve the provision of temporary medical benefits to those from whom medical improvement might be expected with proper care but have no health insurance, and a fourth program would involve a benefit offset provision in the SSD program which would allow an individual to draw reduced benefits if earning over the SGA amount (currently \$800/month). There is also a proposal for giving ongoing health benefits to those individuals, like HIV positive individuals and those suffering from mood disorders, who need extensive medication in order to be employed and now must rely on indigency-based

120. Monroe Berkowitz, John Burton, and Debra Brucker, *Designing an Early Intervention Experiment and Demonstration Approach for The Social Security Administration*, Program for Disability Research, Early Intervention Project at www.disabilityresearch.rutgers.edu/eiproject.htm (last checked 5/10/05).

121. *Id.*

122. *Id.*

123. *Id.*

Medicaid.¹²⁴

V. PROPOSALS FOR CHANGE IN THE DISABILITY BENEFITS SYSTEM

There have been many suggestions as to how to attain a more reasonable, compassionate and consistent social disability policy in this country, and this article will not summarize them all here. But when looked at through the lens of historical development, our SSD and SSI disability benefit programs suffer from one glaring flaw: the perceived finality of the determination of disability. The length of time it takes to obtain such a determination, the formality of its pronouncement (through an Administrative Law Judge after consultation with medical and vocational experts, if necessary), the statutory definition of recognized disability in the context of a “permanent” and later long-term event, and the view that both SSD and SSI are earned “benefits” accruing to an individual because of the limitations caused by his or her health condition, all emphasize both the permanency of the beneficiary’s condition and the desirability of maintaining such status. When combined with the lack of any return to work program employed at any stage prior to a final determination, the programs almost ensure that the hard-won status of being “disabled” will not be voluntarily surrendered. And that designation certainly has its rewards. As Diller correctly notes, even in very conservative cost-conscious times when other welfare programs were being slashed, reengineered and returned to the states, the disability programs have been tinkered with only on the fringes.¹²⁵ But the advances of modern medicine have both extended the age of useful work life and minimized the effects of acute disabling events.¹²⁶ In today’s world, a disability claimant is quite possibly a younger individual with a chronic back, circulatory, or diabetic condition that might be improved through proper medical treatment and significant lifestyle changes, including smoking cessation, diet and exercise. In this context, the rationale underlying

124. Isbell, *supra* note 118.

125. Entitlement, *supra* note 16, at 448. Congress has limited benefits in children’s SSI cases. Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, 110 Stat 2105 (codified as amended in scattered sections of 42 U.S.C.).

126. See GAO Report 02-597, *supra* note 1, at 13-14.

our disability benefit systems, that of “early retirement” because of a “permanent” condition, is no longer fully warranted.¹²⁷ Instead, it might be better to re-conceive the SSD/SSI disability benefit programs as a means of providing transitional support during a period of retraining and rehabilitation, rather than as a source of long-term income support. This would involve the recognition and the expectation that, to at least some extent, disabled people are in charge of both their own condition and their future, and a return or entry into the economic mainstream of life is to be expected of all but the most functionally incapacitated. This expectation is in accord with the policies of the private disability insurers studied by the GAO and European countries, as well as well within the moral parameters of the reciprocity doctrine set out above. As noted by Dr. Edward Stieglitz in the initial hearings on the disability program, a person becomes disabled “when an individual quits trying.”¹²⁸ The current system discourages “trying,” because of a number of factors that have been discussed previously. The list of “reforms” that have been made in the program in recent years catalogue efforts to remove impediments to “trying”, such as penalties in medical insurance benefits or arbitrary loss of benefits by means of temporary and unsustained work. But the underlying assumptions of the program remain undisturbed, and it is these that must be systemically altered.

Certainly medical care is essential for most persons with disabilities, and they should not be penalized through the loss of government-paid medical care by a return to work. I would propose that Medicaid be provided to all uninsured applicants who meet the requirements for vocational services under the federal-state vocational rehabilitation program. These services are already arguably provided to any individual with a disability who needs vocational services and who requires medical care to become employable under section 103(6)(A)-(F) of the Rehabilitation Act,¹²⁹

127. Dissonant, *supra* note 5, at 1067.

128. See Entitlement, *supra* note 16, at n.141.

129. Section 103(a)(6) of the Rehabilitation Act as amended provides that the following services can be provided by the Vocational Rehabilitation Service:

to the extent that financial support is not readily available from a source (such as through health insurance of the individual or through comparable services and benefits consistent with section 721(a)(8)(A) of this title, other than the designated State unit, diagnosis and treatment of physical and mental impairments,

although this must be provided as part of a comprehensive individualized employment plan overseen by the state vocational rehabilitation agency.¹³⁰ I propose that the only precondition for the provision of such medical care is that the individual be looking for or preparing for work. Once employed, the individual would continue to qualify for any uninsured medical care necessary to maintain employment.

The argument might arise that this particular proposal may create an incentive on the part of a person with a disability to quit his or her current job and apply for medical coverage and vocational services while looking for work. But our current system creates its own disincentives to work in order to obtain medical care, and the same such incentives might and do encourage uninsured workers to reduce earnings in order to qualify for Medicaid. At least this proposal would encourage a return to and maintenance of paid employment, with resulting payment of taxes and reduction of dependence on the part of the person with a disability. With respect to vocational rehabilitation services, I propose that all current and prospective applicants for SSD and SSI benefits, except those screened out by the SSA as clearly unemployable, should be referred to a vocational rehabilitation counselor prior to any hearing as to disability status by an Administrative Law Judge. The investigation and initial determination(s) by the state disability determination services can proceed at the same time as any vocational services which are provided to the applicant, and an award of disability benefits could

including -

(A) corrective surgery or therapeutic treatment necessary to correct or substantially modify a physical or mental condition that constitutes a substantial impediment to employment, but is of such a nature that such correction may reasonably be expected to eliminate or reduce such impediment to employment within a reasonable length of time; (B) necessary hospitalization in connection with surgery or treatment; (C) prosthetic and orthotic devices; (D) eyeglasses and visual services as prescribed by qualified personnel who meet State licensure laws and who are selected by the individual; (E) special services (including transplantation and dialysis), artificial kidneys, and supplies necessary for treatment of individuals with end-stage renal disease; (F) diagnosis and treatment of mental and emotional disorders by qualified personnel who meet State licensure laws.

130. Rehabilitation Act of 1973 § 102(b)(1); 29 U.S.C. § 723 (b)(1) (1998).

not be denied because of temporary employment obtained through a vocational rehabilitation referral. While the referral provisions were in the Social Security Act prior to the Ticket to Work amendments, they apparently were not often used and suffered from a reimbursement system that created little incentive for success on the part of the vocational system involved.¹³¹ Vocational counselors should have access to the relevant medical and vocational data in the Social Security Disability claim file.¹³² The State-Federal VR system must be changed in such a way as to encourage the providing of vocational services by alternate (private) providers, including employment networks (ENs), and the compensation under the Ticket to Work outcome payment system should be increased and accelerated in order to attract smaller private providers. The work incentive provisions relating to SSI earnings should be included in the SSD system as contemplated in one of the current pilot programs. It is essential that vocational counselors from private industry are encouraged to supplement the supply of counselors available in the state programs, as recent studies have demonstrated significant delays in providing of services even in the lightly-used Ticket to Work program.¹³³ As Growick correctly points out, the state-federal VR System can no longer be the sole provider of rehabilitation services to disabled individuals, and a specific delineation between the roles of private and public VR providers is sorely needed.¹³⁴ Perhaps Weber's suggestion that positive affirmative action in the form of set-asides or targets in employment for disabled people¹³⁵

131. Bruce Growick, *The Political Implications of TTWWIA*, THE REHABILITATION PROFESSIONAL, Nov.- Dec. 2000, at 31, 32.

132. See Growick & Drew, *supra* note 34, at 51-52. As Growick notes: In other indemnity programs in which rehabilitation professionals are paid to return beneficiaries to work, the insurance company provides them with access to critical background information about prospective clients in order to make informed decisions about employment feasibility. Without access to such information in the referral process, rehabilitation providers spend an inordinate amount of time and/or money collecting data to determine feasibility for services when data is readily available....

Id.

133. GAO Report 02-597, *supra* note 1 (citing testimony before TTWIA Advisory Panel Quarterly Meeting).

134. *Id.* at 51.

135. Weber, *Beyond the Americans with Disabilities Act*, *supra* note 99. See

may be required, for this at least mandates a presence that would tend to both break down prejudice and build up confidence among disabled individuals and may significantly expand the pool of jobs available for the disabled. With respect to the feasibility of this particular proposal, it should be noted that the GAO Report cites significant government financial assistance and incentives existing in the European countries studied to encourage the employment of individuals with disabilities and pay for any accommodations necessary, as well as legislated mandatory set-asides.¹³⁶

But the ultimate cornerstone of any disability benefit reform program must be based upon recognition of both the power and the obligation of the individual suffering from a disability, to take necessary action to “mitigate” such disability. In short, I propose that for an individual to qualify for and continue to qualify for disability, such person must be willing to adopt certain healthy “lifestyle” changes known to assist in restoring health and to avail him or herself of the options available under the Rehabilitation Act for vocational, educational, and medical care. Smoking cessation, diet counseling, a reasonable exercise program, and addictions counseling:¹³⁷ all should be options that may be required of a claimant in certain situations.

In order to implement such a system, it would be necessary to alter the disability determination process in such a manner as to expand the range of possible decisions by the Agency. In addition to a finding of “disabled” or “not disabled,” there should be a third category that could be found in disability applicants, that of “temporarily disabled.” This category would encompass most younger individuals (and perhaps some older individuals with less serious impairments) whom the fact finder determines could benefit from proper medical care, vocational counseling and healthy lifestyle choices. The one-year duration requirement for these individuals would be waived, and cash benefits could be provided for a limited

also Wax, supra note 73 (arguing that efficiency must be evaluated to the economy as a whole rather than to the individual employer, that is, savings in the form of unpaid disability income benefits must be factored in when evaluating the efficiency of a proposed accommodation).

136. GAO Report 01-153, *supra* note 25, at 28.

137. As noted before, I feel the 1994 amendments in the DA&A disability category, which mandated addiction treatment and limited benefits resulting from such impairments to three years, was a prudent alternative which has never really been implemented.

time, as well as medical care, vocational counseling, and educational services. As part of an award of temporary disability benefits, certain healthy lifestyle changes, such as smoking cessation, diet and addiction counseling, and a regular exercise program, in accordance with the recommendations of treating or consulting physicians or agency examiners, could be required of the claimant. In the event of a disagreement between the treating and agency physicians concerning the propriety of a lifestyle change only a well-supported opinion by the treating physician that such change would not be in the best health interests of the claimant would be determinative.¹³⁸ After the initial temporary benefit period had expired, the applicant who still sought a finding of permanent disability could proceed with his application, but the failure of the claimant to cooperate in a vocational rehabilitation program, comply with medical treatment recommendations or make recommended lifestyle changes could be considered as factors in the ultimate determination of permanent disability.

While the above proposal is very much in line with the practices of the private disability insurers in administering their own disability programs, there are arguments that such changes, especially the liberalization of the definition of “disability” to include “temporarily disabled” persons, might increase the disability rolls precipitously and not prove cost-effective. Interestingly enough, insurance companies providing long-term disability insurance benefits reported a return to work success rate of 38% for those who used rehabilitation services,¹³⁹ although as noted above only 2-3% of the long-term disabled ever get off the insurers’ disability rolls. A 1995 GAO study of the VA Vocational program noted a similar success

138. See 20 CFR section 404.1527, with respect to the weight accorded the claimant’s treating physician as opposed to agency physicians. There has been considerable litigation on this subject, and it is likely that the agency would not choose to interfere or override any recommendations. However, it is hard to see how such beneficial recommendations such as an exercise program, weight loss, and smoking cessation could be vetoed by a treating physician, especially in light of the numerous references to such recommendations often present in treating physician notes reviewed at the disability hearing.

139. Dissonant, *supra* note 5, at 1072 n.320 (quoting a 1994 Insurance Survey reported in National Academy of Social Insurance, REPORT OF DISABILITY POLICY PANEL, BALANCING SECURITY AND OPPORTUNITY: THE CHALLENGE OF DISABILITY INCOME POLICY (Jerry L. Manshaw & Virginia P. Reno, eds., 1996)).

rate (37%) in the state VR programs. This is a further incentive for early intervention of vocational rehabilitation.

In recognition of the greater functionality of our aging population and the statutory increase in the retirement age of younger workers, the Medical-Vocational guidelines would be gradually increased in tandem with the retirement age applicable to the individual applicant. In other words, the Grids, which provide for presumptive disability based upon certain factors, such as age, vocational experience, and education, would be increased so that the effective age at which a claimant “crosses the grid” would be increased so that the “sedentary” work grid guideline was crossed 15 years before retirement age for every claimant, the “light” grid guideline crossed at 10 years before retirement age, and so on. Congress has increased the retirement age but SSA has not adjusted its grids to reflect this change, and the resulting marginal changes may in the aggregate be catastrophic to the program, considering the already-anticipated insolvency of the disability trust fund in 2023.¹⁴⁰ Recognizing that many applicants are suffering from conditions that either clearly preclude employment or are not reasonably susceptible to lifestyle changes and aggressive medical and vocational intervention, the option of a finding of permanent disability in both the initial and hearing stages of the disability determination process would be retained for the most severely and/or permanently disabled. This is similar to the screening of cases by private disability insurers, where those who offer little vocational potential are placed in a different and less service-intensive category. To ensure uniformity in decisions, transferability of skills (often used as a bar to disability in older individuals who otherwise qualify under the grids) would be eliminated as a bar to a finding of permanent disability in cases based upon the Medical-Vocational Guidelines in all but those with skilled past professional experience.¹⁴¹

This proposal would recognize the inherent obligation on the part of every individual to take charge of his or her own future in terms of medical and vocational outcome. But it also would recognize the tremendous potential present in those considered by themselves or others to be “disabled” to contribute to improving their own medical

140. GAO Report 01-153, *supra* note 25, at 3.

141. See Ken Matheny, *Social Security Disability and the Older Worker: A Proposal for Reform*, 10 GEO. J. ON POVERTY L. & POL'Y 37 (2003).

condition and contribute economically to our society. It also recognizes the fact that people suffering from a medical or psychological disability generally are at a disadvantage educationally and vocationally in comparison to those who are not suffering from a disability, and it gives such individuals both the support and the tools of medical rehabilitation and vocational self-sufficiency.

This proposal would also have the advantage of serving the class of people who are denied benefits under the current SSD and SSI systems. Statistics from the Social Security Agency itself indicate that these individuals, despite being found “not disabled” by health reasons by the Agency fact finders, nevertheless continue to be unemployed for perceived health reasons at a rate greater than 50%.¹⁴² Referral to a vocational rehabilitation agency with the ability to offer medical, vocational and education services would be helpful to many of these denied applicants.¹⁴³ The SSA employees, especially those involved in determination of disability, are also cognizant of the general disability law and protections afforded to disabled individuals, and they could at least give some form notice of the availability of such remedies and the local agencies responsible for enforcement to all applicants.

I also believe that the SSA is in the best position of any federal agency to implement a unified disability policy with respect to the persons suffering from a disability in our country. This agency is the initial contact point for most people with a disability and is also in possession of the most information, such as work and education history, medical records, IQ and psychological testing, and alleged limitations that would be relevant to a rehabilitation program. The agency also has a great deal of power to influence applicants in that the benefits it confers are often urgently needed. Through its use of medical and vocational experts at many different levels of the disability determination process, the agency has access to resources necessary to affect a comprehensive medical and vocational

142. See GAO Report HRD-90-2 (1989), *Social Security Disability: Denied Applicants' Health and Financial Status Compared with Beneficiaries*, at 21-22, available at <http://161.203.16.4/d2d+7/140019.pdf>.

143. It should be noted that, in addition to containing a broader definition of disability than in the SSD and SSI regulations, under section 102(a)(B)(2) of the Rehabilitation Act, as amended, there is a presumption of eligibility of an individual for services provided under the Act.

rehabilitation plan for a person who might benefit from this. In actuality, many of these proposals are similar to the ones at least arguably suggested by prior GAO reports.

Whether the implementation of these changes will be cost-effective is another matter. Certainly, implementation of these changes would hopefully divert a certain percentage of claimants who would otherwise qualify for disability benefits from the disability rolls and into gainful, tax-paying employment. But it would also provide benefits to temporarily disabled persons who might not otherwise qualify for disability benefits, and put significant strain through referrals on a publicly funded vocational rehabilitation system. Under the Rehabilitation Act, however, it is clear that almost all of the persons referred under this proposal would be eligible for these services anyway, and the increased utilization of these services should be viewed as ultimately a net plus for society in general and the persons with disabilities in particular. The increase in disability rolls could not ultimately be measured in terms of the net yearly increase or decrease in benefit payments or beneficiaries. Because the disability system, like the social security system of which it is a part, is a pay-as-you-go system, there are tremendous unfunded liabilities existing with respect to current or future beneficiaries, and any reduction in permanent (as opposed to current) beneficiaries might be significant even if only incremental. The GAO study confirmed significant up-front expenses on the part of the involved disability insurers still yielded significant savings. The un-funded liabilities with respect to SSI beneficiaries, which are supported by general revenue and state funding and are not even arguably supported by the illusory "trust funds" supposedly maintained in the Social Security programs, are more obviously dangerous to future workers and taxpayers. And you must add to the program savings resulting from the reduction in the rolls of the "permanently" disabled the intangible benefits to individuals and society as a whole inherent in any medical and vocational improvements on the part of the prospective disability applicants.

A determination of temporary disability would give the claimant the benefit of vocational, medical and educational services that might return such a claimant to economic and personal independence. If it did not, the claimant's condition could be reviewed by the decision-maker through the prism of the experience over the temporary disability period. For example, if the claimant was placed at a

sedentary occupation and could not successfully continue such work on a day-to-day basis, this could be considered evidence that the individual was permanently disabled from any occupation. There are clearly many claimants whose condition will not allow them to work full-time at any occupation and many others whose condition will deteriorate over the temporary disability period. However, if the claimant's main disabling condition was largely exacerbated by obesity and shortness of breath and the claimant refused to comply with recommendations for diet counseling, exercise, or smoking cessation a decision-maker might consider this fact, with certain limitations, in denying a permanent disability application. The requirement of healthy lifestyle changes on the part of the claimant does no disservice to the claimant, as it can only help him in improving his own health and functionality. Of course, this additional factor in the ultimate finding of disability could be applied punitively, but that is a possibility for any additional factor to be considered by the decision-maker in the disability program; the principle of liberal construction of the Act, and the independence of the ALJ decision on the issue of disability, give considerable protection to the claimant in this regard.

VI. SOME PERSONAL OBSERVATIONS

As an ALJ, I can really not overemphasize the discouragement and hopelessness exhibited by many disability applicants at their disability hearings. These people are by and large honorable individuals who have been "trapped" by a series of unfortunate factors, including their own attitudes and background, as well as their medical, vocational, and educational factors, and fully believe that they are "disabled" from all productive activities in our society. For years their primary focus has been on proving their "disability" and on dealing with and documenting their medical and psychological impairments. Most have had no vocational referral and have not even considered the possibility of performing some of the jobs suggested by a vocational expert at their disability hearing as within their given functional capacity. The initial concept of "early retirement" embedded in the disability benefits programs leaves an adjudicator little option in disability cases but to either deny or grant the benefits sought. In neither case is the decision necessarily the right one when considering the best interests of the individual claimant, or society as

a whole. As noted by the Social Security system itself, over half of the persons denied benefits for disability were not working three years later and over three-quarters cited health reasons as their main reason for not working. Obviously over half of these claimants were not assisted in any way by the Agency, either through an award of benefits or referral to vocational rehabilitation agencies. Nor am I convinced that many allowances, especially those based on the Medical Vocational Guidelines, are necessarily in the best interests of society or the claimants themselves. As noted in the previous section on medical advances, one of the most consistent findings in the medical literature is that exercise in any form seems to improve health outcomes in most cases. In many ways, work is a forced form of exercise, often in older individuals the sole inducement to get physically moving in our culture of television, on-line computer services and telephones. Add to this the fact that many disability cases are based upon subjective pain, which can be reduced by the distraction and socialization inherent in any job, and the finding of disability becomes even more problematic with respect to the best interests of the individual involved. For pain, depression and many common physical ailments the isolation and physical inertia often resulting from a finding of permanent disability seem exactly the worst prescription for a worker, especially an older one. As an Agency that has been made in part responsible for the well being of people with disabilities, the SSA owes them much more than it is currently offering in terms of prompt, rational and beneficial decisions. As the Agency that often is the first and sole contact point for individuals with disabilities and, the SSA must be more proactive in informing these individuals of the laws protecting them from discrimination and of the services available for their treatment, training, education and other vocational services. As the Agency that has been noted for its professionalism and compassion, the SSA must take the lead in giving disabled individuals in our society the principles of personal empowerment and self-reliance that underlie the Americans with Disability Act.

